

Opening Statement of the Honorable Joseph R. Pitts
Subcommittee on Health
Hearing on “Keeping the Promise: How Better Managing Medicare Can Protect Seniors’
Benefits and Save Them Money”
March 4, 2014

(As Prepared for Delivery)

In Fiscal Year 2014, the Medicare program will cover nearly 54 million Americans, and the Congressional Budget Office (CBO) estimates that total Medicare spending will be approximately \$603 billion; \$591 billion of which will be spent on benefits.

According to the Department of Health and Human Service’s (HHS) FY2013 Agency Financial Report, the improper payment rate for Medicare fee-for-service (FFS) was 10.1% last year. Adding in the improper payments for Parts C and D, with error rates of 11.4% and 3.1%, respectively, improper payments totaled over \$49.8 billion.

Independent estimates of the real cost of waste, fraud, and abuse in Medicare are much higher.

Why are these figures important?

The Medicare Trust Fund is set to go bankrupt sometime in the next decade. Absent Congressional action, the Congressional Research Service (CRS) has stated Part A benefits cannot be paid out while the Trust Fund is insolvent.

That is simply unacceptable. We cannot afford a future where our seniors’ hospital bills go unpaid. Every taxpayer dollar must be protected.

Some of my colleagues have suggested that merely eliminating the multi-billion dollar losses due to inefficiency and fraud will alone fix the insolvency problem.

That claim is, frankly, false.

While reducing waste, fraud, and abuse—and managing the program more effectively—should be an Administration priority, that alone is not enough to address Medicare’s spending problem.

However, critics are correct that a Congressional solution is needed.

We must do everything in our power to safeguard the money in the Trust Fund, until such time as Congress accepts its responsibility to make structural changes to save the program for the millions who depend on it.

Medicare uses a variety of contractors to assist in paying provider claims, delivering benefits, and carrying out program integrity and oversight functions.

Many of these contractors have valuable experience fighting fraud and efficiently managing health insurance programs. Yet sometimes federal law or administrative barriers prevent us from using their expertise to prevent waste, fraud, and mismanagement in the Medicare program.

Other times, all that is missing is a dose of common sense and leadership.

This Committee has for years studied the problem and reviewed potential new programs to help CMS fight waste, fraud, and abuse.

This is not one of these hearings.

Today's hearing is an opportunity to hear from experts about the challenges CMS faces in administering the program.

In fact, today's hearing is a first step toward a broader long-term effort to build consensus about the best ways to modernize the Medicare program – in its management, operations, and accountability.

And the best way to strengthen Medicare is to help improve and modernize the business model of the agency that oversees the Medicare program: CMS.

The purpose of today's hearing is to examine how CMS currently uses and oversees these contractors to lessen program vulnerabilities and protect seniors' benefits by increasing accountability and cost-effectiveness.

Long term, I hope to work with my colleagues to identify barriers in federal law and within CMS itself that prevent contractors from fighting waste, inefficiency, fraud, and abuse—and I hope we will address them.

I am pleased to have witnesses from both GAO and the HHS OIG with us today to discuss the types and functions of Medicare contractors and how the program can better manage them to meet its goals.

I would note that the HHS OIG is releasing two new reports today on these topics, and I look forward to the testimony of all of our witnesses.

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